CREDIT OR DEBIT CARD

_Visa _MasterCard _Discover _Amex

Cardholder Name (Print):

Credit Card #:	CVC (3-Digit #):

Expiration Date:

ELECTRONIC CHECK (DEBIT)

Account Holder Name (Print):

_Checking	_Savings

(Include a voided check or deposit slip with application)

Bank Name:

Routine # (9 Digit # at Bottom of Check):

Account #:

PAYMENT AUTHORIZATION:

I authorize Polish Dental enter to bill my credit/debit card or electronically debit my checking account for this membership. My membership will remain in force until I notify Polish Dental Center in writing to cancel. The processing of your application will be delayed. Charges will appear as Polish Dental Center on your statement. This application along with the terms and conditions, and other details in this brochure will serve as your membership agreement. Please keep this brochure for your records.

Signature Authorization:	Date:

You can **mail or email registration** to: **Polish Dental Center**

629 Beaver Ruin Road Suite A, Lilburn, Georgia 30047
Email: office @smilepolish.com
Designate Preferred Office: ___ Alpharetta, ___ Lilburn

TERMS & CONDITIONS

Program Description

Once a member has paid and enrolled into the plan, they are entitled to receive certain dental services at a reduced rate. Provider shall add or discontinue selective dental services and modify the discounted fees without prior notice.

Membership Term & Payment Options

The initial and subsequent enrollment is for 12 months. Payment is due in full at time of enrollment.

Membership Fee payment Due and Billing Authorization

Upon joining, you shall authorize Avala Dental to bill your credit card or electronic check (debit) for the balance due. If dues are not received on or before the annual renewal date there will be an interruption of membership and no access to discounted services.

Automatic Renewal of Membership Term

Plan will automatically renew at the end of your membership term using the form of payment on file for the fees due unless the plan is cancelled 15 days before your annual renewal date.

Membership Cancellation and Refund Policy

You can cancel membership for any reason within the first 30 days of enrollment and receive a refund of membership fees minus the non-refundable processing fee. On automatic renewals, you must cancel 15 days before the renewal date, you may send a cancellation letter to the office email, fax, or address on this brochure.

Cancellation/Refund Policy – After First 30 Days

No refunds will be granted after the 30 days cancellation period offered for the initial enrollment and all automatic renewals.

Payment of Fees Charged by Provider of Dental Services

Payments for dental services are due at time of service.

Provider and Administration Termination Conditions.

Polish Dental Center reserve the right to terminate this plan and its members for any reason, including non-payment.

Complaints Procedure

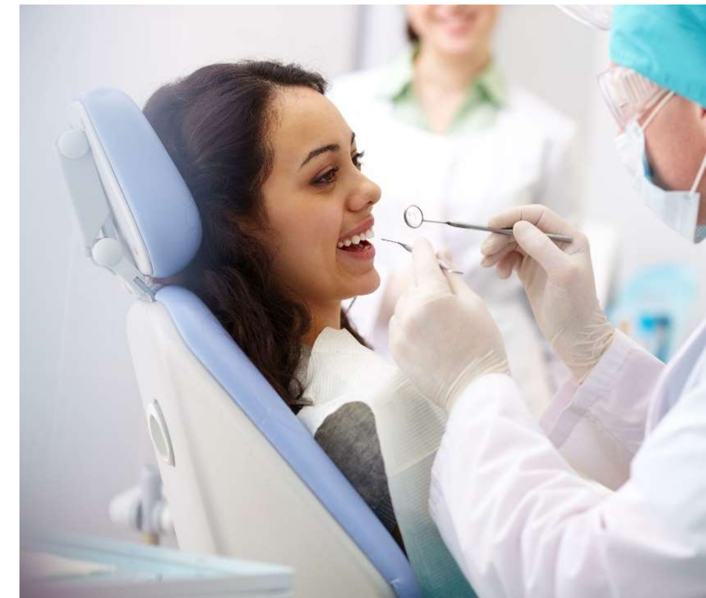
Any complaints regarding this plan or membership shall contact the Ofc Mgr or CFO by phone, email, fax, or address on this brochure.

Membership Non-Assignable

Member rights under this Agreement may not be assigned or delegated without prior written consent from Avala Dental.

Membership Acknowledgements

Upon joining this program, you acknowledge you have read, understand and accept the terms and conditions of this reduced fee dental plan.



POLISH DENTAL CENTER

Dental Discount Plan

Individuals , Families & Small Businesses
(This Plan is Not an Insurance Policy)

Dental Services and Plan Administration Provided By:

Polish Dental Centers

Lilburn
Platinum Pointe Medical Complex
629 Beaver Ruin Rd, Ste A
Lilburn, GA 30047
Phone Number: 770-696-4144

Alpharetta
4640 Valais Ct , Ste 102
Alpharetta, GA 30022
Phone Number: 770-642-4711

DISCOUNT DENTAL PLAN

WHY A REDUCED FEE DENTAL PLAN IS NEEDED?

Provide individuals and families who do not have dental insurance access to reduced fees in today's economy.

WHO IS ELIGIBLE?

Member, spouse, children, and relatives financially dependent on member.

WHO IS THE PROVIDER OF THE DENTAL SERVICES?

The Doctors of Polish Dental Centers and their qualified staff.

WHERE ARE SERVICES PERFORMED?

Polish Dental Centers
Lilburn, Georgia 30047 or Alpharetta, Georgia 30022

HOW TO USE MEMBERSHIP (CONTACT PROVIDER)?

After becoming a member, call offices @ 470.447.0660
Identify yourself as a member and schedule an appointment.
Visit our website @ www.smilepolish.com
Email: office@smilepolish.com or alpha@smilepolish.com

SAMPLING OF TREATMENTS

DENTAL PROCEDURES	REGULAR PRICE	PLAN PRICE	SAVINGS
- Routine Six Month Check	$ 65	$ 25	61%
- Full Mouth X-Rays	$ 163	$ 65	60%
- Four Bitewing X-Rays	$ 85	$ 35	59%
- Adult Teeth Cleaning	$ 115	$ 65	44%
- 4 Surface White Filing for all Teeth	$ 427	$ 250	42%
- Single Crown – All Porcelain	$ 1550	$ 799	49%
- Root Canal Treatment – Front Tooth	$ 930	$ 450	52%
- Perio Scaling and Root Planning (Per Quadrant)	$ 318	$ 159	50%
- Full Upper Denture	$ 2312	$ 1000	57%
- Single Tooth Removal – Surgical Extraction	$ 352	$ 150	41%

THIS PLAN IS NOT DENTAL INSURANCE

IT IS A REDUCED FEE PROGRAM FOR PATIENTS WITHOUT INSURANCE

OFFERING 20 – 65% DISCOUNTS

WHAT ARE THE BENEFITS OF MEMBERSHIP?

- Priority appointment times
- 20 – 65% Discounts on Covered Dental Procedures
- No Waiting Periods, No Annual Limits
- No Maximum
- No Deductible
- No Exclusions for Pre-existing Conditions
- No Age Limits

WHAT DENISTRY SERVICES ARE PERFORMED?

- Radiographs & Exams
- Braces
- Crowns & Bridges
- Dentures
- Dental Implants
- Routine Cleaning & Deep Cleanings
- Root Canal & Tooth Extractions

POTENTIAL SAVINGS BASED ON FEES BASED ON UCR FEES

(See table above.)

- Provider reserves the right to change fees without notice.
- Provider reserves the right to add/delete services for plan

DENTAL LIMITATIONS AND EXCLUSIONS

- Only services diagnosed by your provider will be a eligible on this plan.
- Warranty of services are based on routine dental maintenance.
- Injuries or conditions covered under Workmen's Comp Laws
- This plan can not be used in conjunction with an insurance policy.

PATIENTS WITHOUT INSURANCE

MEMBERSHIP BASED ON 12 MONTH AGREEMENT

(Family members include member/spouse/eligible dependents)

	Annually (20% Less) (If Paid Up Front)
Member Only	_$ 60.00
Member + 1	_$ 99.00
Member + 2	_$ 120.00
Member + 3 >	_$ 144.00

PROCESSING FEE

There is a $15 non-refundable processing fee.

MEMBER INFORMATION

First Name: (Print)	MI:
Last Name: (Print)	DOB:

Address:

City:	St:	Zip:

Cell Phone #:

Other Phone #:

E-Mail:

FAMILY MEMBERS

(Add spouse, life partner, eligible dependents living in member household)

First	Last	DOB	Relation